FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042085

Facility Name: THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT SOUTH SHORE

Address: 2425 East 71st (Number) Chicago (City) 60616 (Zip Code)

County: Cook

Telephone Number: (773) 721-5000 **Fax #** (773) 721-6850

IDPA ID Number: 36-3938428

Date of Initial License for Current Owners: 10/23/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) Noshir R. Daruwalla, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT SOU # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	238	Skilled (SNF)	238	87,108	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	238	TOTALS	238	87,108	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	70,192	4,123	6,774	81,089	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	70,192	4,123	6,774	81,089	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.09%

D. How many bed-hold days during this year were paid by Public Aid? 2,685 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/23/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/23/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 83 and days of care provided 5,396

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	269,390	68,355	14,348	352,093		352,093		352,093			1
2	Food Purchase		346,817		346,817	(19,618)	327,199	(1,036)	326,163			2
3	Housekeeping	63,080	43,571	294,043	400,694		400,694		400,694			3
4	Laundry	15,776	19,234		35,010		35,010		35,010			4
5	Heat and Other Utilities			197,092	197,092		197,092	(14,547)	182,545			5
6	Maintenance	93,905	44,661	78,360	216,926		216,926	1,461	218,387			6
7	Other (specify):*							(21)	(21)			7
8	**TOTAL General Services**	442,151	522,638	583,843	1,548,632	(19,618)	1,529,014	(14,143)	1,514,871			8
	B. Health Care and Programs											
9	Medical Director			28,513	28,513		28,513		28,513			9
10	Nursing and Medical Records	2,760,449	205,645	202,745	3,168,839		3,168,839	983	3,169,822			10
10a	Therapy	113,883	1,389	18,917	134,189		134,189		134,189			10a
11	Activities	174,306	21,752	421	196,479		196,479		196,479			11
12	Social Services	83,183		6,050	89,233		89,233		89,233			12
13	Nurse Aide Training	25,351		6,644	31,995		31,995		31,995			13
14	Program Transportation			3,875	3,875		3,875	1,975	5,850			14
15	Other (specify):*							201	201			15
16	**TOTAL Health Care and Programs**	3,157,172	228,786	267,165	3,653,123		3,653,123	3,159	3,656,282			16
	C. General Administration											
17	Administrative	145,556		510,441	655,997		655,997	(199,294)	456,703			17
18	Directors Fees											18
19	Professional Services			188,916	188,916		188,916	2,107	191,023			19
20	Dues, Fees, Subscriptions & Promotions			127,031	127,031		127,031	(60,213)	66,818			20
21	Clerical & General Office Expenses	299,164	67,303	131,448	497,915		497,915	71,920	569,835			21
22	Employee Benefits & Payroll Taxes			620,486	620,486	19,618	640,104	(13,750)	626,354			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,031	5,031		5,031	1,112	6,143			24
25	Other Admin. Staff Transportation			1,390	1,390		1,390	544	1,934			25
26	Insurance-Prop.Liab.Malpractice			114,725	114,725		114,725	269	114,994			26
27	Other (specify):*							28,519	28,519			27
28	**TOTAL General Administration**	444,720	67,303	1,699,468	2,211,491	19,618	2,231,109	(168,786)	2,062,323			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,044,043	818,727	2,550,476	7,413,246		7,413,246	(179,770)	7,233,476			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT SOUTH SHORE
0042085
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	19,618	
2	FOOD		19,618

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RE!#0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			99,904	99,904		99,904	245,390	345,294			30
31	Amortization of Pre-Op. & Org.							6,734	6,734			31
32	Interest			362,645	362,645		362,645	700,025	1,062,670			32
33	Real Estate Taxes			524,172	524,172		524,172		524,172			33
34	Rent-Facility & Grounds			1,441,570	1,441,570		1,441,570	(1,419,049)	22,521			34
35	Rent-Equipment & Vehicles			11,938	11,938		11,938	6,857	18,795			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,440,229	2,440,229		2,440,229	(460,043)	1,980,186			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		176,689	309,062	485,751		485,751	35	485,786			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,662	130,662		130,662		130,662			42
43	Other (specify):*	66,581			66,581		66,581	(66,581)				43
44	**TOTAL Special Cost Centers**	66,581	176,689	439,724	682,994		682,994	(66,546)	616,448			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,110,624	995,416	5,430,429	10,536,469		10,536,469	(706,359)	9,830,110			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(202,259)	30		9
10	Interest and Other Investment Income	(13,628)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(176)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,353)	21		18
19	Entertainment				19
20	Contributions	(18,858)	20		20
21	Owner or Key-Man Insurance	(13,750)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(75,657)	21		24
25	Fund Raising, Advertising and Promotional	(44,897)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(88,910)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (465,488)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(240,871)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (240,871)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (706,359)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT SOUTH SI

ID# 0042085

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Misc. Income - Food Rebates	(860)	2	2
3	Misc. Income - Copies	(1,217)	21	3
4	Misc. Income - Jury Duty	(103)	10	4
5	Political Contributions - ICLTC	(396)	20	5
6	Bank Charges	(760)	21	6
7	Out of Period Legal Cost	(545)	19	7
8	Trust Fees - Building Partnership	(250)	21	8
9	Marketing Salary	(66,581)	43	9
10	Cable TV	(15,436)	5	10
11	Legal & Accounting Fees - Bldg. Partnership	(2,762)	19	11
12				12
13				13
14				14
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88				88
89				89
90	Total	(88,910)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(1,036)											(1,036)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(15,436)		889									(14,547)	5
6	Maintenance			1,461									1,461	6
7	Other (specify):*			(21)									(21)	7
8	**TOTAL General Services**	(16,472)		2,329									(14,143)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(103)		1,086									983	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			1,975									1,975	14
15	Other (specify):*			201									201	15
16	**TOTAL Health Care and Programs**	(103)		3,262									3,159	16
	C. General Administration													
17	Administrative		47,662		(114,513)	(109,444)	(22,999)						(199,294)	17
18	Directors Fees													18
19	Professional Services	(3,307)	2,762	2,193			459						2,107	19
20	Fees, Subscriptions & Promotions	(64,151)		3,142			796						(60,213)	20
21	Clerical & General Office Expenses	(85,237)	505	149,904		1,090	5,658						71,920	21
22	Employee Benefits & Payroll Taxes	(13,750)											(13,750)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,081			31						1,112	24
25	Other Admin. Staff Transportation			544									544	25
26	Insurance-Prop.Liab.Malpractice			269									269	26
27	Other (specify):*			21,921	2,943	355	3,300						28,519	27
28	**TOTAL General Administration**	(166,445)	50,929	179,054	(111,570)	(107,999)	(12,755)						(168,786)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(183,020)	50,929	184,645	(111,570)	(107,999)	(12,755)						(179,770)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RI # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(202,259)	442,093	5,556									245,390	30
31	Amortization of Pre-Op. & Org.		6,734										6,734	31
32	Interest	(13,628)	716,256	(2,603)									700,025	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,429,570)	10,521									(1,419,049)	34
35	Rent-Equipment & Vehicles			6,857									6,857	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(215,887)	(264,487)	20,331									(460,043)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			35									35	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(66,581)											(66,581)	43
44	**TOTAL Special Cost Centers**	(66,581)		35									(66,546)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(465,488)	(213,558)	205,011	(111,570)	(107,999)	(12,755)						(706,359)	45

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE A # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				South Shore Limited		
				Partnership	Chicago	Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	31	Amortization	$	South Shore Limited Partnershp	100.00%	$ 6,734	$ 6,734	1
2	V	30	Depreciation		South Shore Limited Partnershp		442,093	442,093	2
3	V	32	Interest		South Shore Limited Partnershp		724,703	724,703	3
4	V	34	Land Rent		South Shore Limited Partnershp		12,000	12,000	4
5	V	19	Legal & Accounting		South Shore Limited Partnershp		2,762	2,762	5
6	V	17	Management Fees		South Shore Limited Partnershp		47,662	47,662	6
7	V	21	Trust Fees		South Shore Limited Partnershp		250	250	7
8	V	21	Miscellaneous		South Shore Limited Partnershp		255	255	8
9	V	34	Rent	1,441,570	South Shore Limited Partnershp			(1,441,570)	9
10	V	32	Interest Income	8,447	South Shore Limited Partnershp			(8,447)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,450,017			$ 1,236,459	$ * (213,558)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT S(# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 889	$ 889	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	1,461	1,461	16
17	V	7	EMPLOYEE BEN. GEN. SERV.		NUCARE SERVICES CORP.	100.00%	(21)	(21)	17
18	V	10	NURSING ADMIN. COMP.		NUCARE SERVICES CORP.	100.00%	1,086	1,086	18
19	V	14	PROGRAM TRANSPORTATION		NUCARE SERVICES CORP.	100.00%	1,975	1,975	19
20	V	15	HEALTHCARE BENEFITS		NUCARE SERVICES CORP.	100.00%	201	201	20
21	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	2,193	2,193	21
22	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	3,142	3,142	22
23	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	149,904	149,904	23
24	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,081	1,081	24
25	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	544	544	25
26	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	269	269	26
27	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	21,921	21,921	27
28	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	5,556	5,556	28
29	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	(2,603)	(2,603)	29
30	V	34	BUILDING RENT		NUCARE SERVICES CORP.	100.00%	10,521	10,521	30
31	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	6,857	6,857	31
32	V	39	ANCILLARY		NUCARE SERVICES CORP.	100.00%	35	35	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 205,011	$ * 205,011	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT S(# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN	$	NUCARE SERVICES CORP.	100.00%	$ 93,249	$ 93,249	15
16	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	20,078	20,078	16
17	V	17	ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	626	626	17
18	V	17	ADMIN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%	0		18
19	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	1,976	1,976	19
20	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	914	914	20
21	V	27	EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	53	53	21
22	V	27	EMP. BEN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%			22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V	17	MANAGEMENT FEES	228,466				(228,466)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 228,466			$ 116,896	$ * (111,570)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT S(# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	$	JLR MANAGEMENT CORP.	100.00%	$ 8,056	$ 8,056	15
16	V	21	OFFICE		JLR MANAGEMENT CORP.	100.00%	257	257	16
17	V	27	PAYROLL TAXES		JLR MANAGEMENT CORP.	100.00%	355	355	17
18	V								18
19	V								19
20	V								20
21	V	17	MARVIN NEEDLE-CONS. FEES		JLR MANAGEMENT CORP.	100.00%			21
22	V								22
23	V								23
24	V	17	MARK BERGER-CONS. FEES		JLR MANAGEMENT CORP.	100.00%	2,500	2,500	24
25	V	21	SECRETARIAL		JLR MANAGEMENT CORP.	100.00%	833	833	25
26	V								26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	120,000	JLR MANAGEMENT CORP.	100.00%		(120,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 120,000			$ 12,001	$ * (107,999)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT S(# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 18,976	$ 18,976	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK	100.00%	459	459	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK	100.00%	796	796	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK	100.00%	5,658	5,658	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK	100.00%	31	31	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK	100.00%	3,300	3,300	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	41,975	CAREPATH HEALTH NETWORK	100.00%		(41,975)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 41,975			$ 29,220	$ * (12,755)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT S(# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workers Compensation	$ 94,121	Diamond Insurance	40.00%	$ 94,121	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 94,121			$ 94,121	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT S(# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT S(# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT S(# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT S(# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, IN(# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Hartman	Owner	Administrative	20.05%	See Attached	4.72	7.26%	Salary	$ 93,249	17-7	1
2	Robert Hartman	Owner	Administrative	20.05%	See Attached			Mgmt Fees	120,000	17-3	2
3	Jack Rajchenbach	Owner	Administrative	25.00%	See Attached	3	4.62%	Salary	8,056	17-7	3
4	Bernard Hollander	Owner	Administrative	25.00%	See Attached	2	3.08%				4
5	Mark Berger	Relative	Administrator	0.00	See Attached	6.67	16.78%	Salary	38,658	17-1	5
6	Mark Berger	Relative	Administrator	0.00	See Attached			All. Mgmt Fees	2,500	17-7	6
7	David Hartman	Relative	Administrative	0.00	See Attached	0.6	1.33%	Alloc. Nucare	626	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 263,089		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	634,333	8	$ 6,475	$	87,108	$ 889	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	634,333	8	10,636	(714)	87,108	1,461	2
3	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	634,333	8	(156)		87,108	(21)	3
4	10	NURSING ADMIN. COMP.	AVAIL. CENSUS DAYS	634,333	8	7,912	6,671	87,108	1,086	4
5	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	634,333	8	14,386		87,108	1,975	5
6	15	HEALTHCARE BENEFITS	AVAIL. CENSUS DAYS	634,333	8	1,462		87,108	201	6
7	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	634,333	8	15,970		87,108	2,193	7
8	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	634,333	8	22,883		87,108	3,142	8
9	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	634,333	8	1,091,620	894,249	87,108	149,904	9
10	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	634,333	8	7,875		87,108	1,081	10
11	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	634,333	8	3,960		87,108	544	11
12	26	INSURANCE	AVAIL. CENSUS DAYS	634,333	8	1,958		87,108	269	12
13	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	634,333	8	159,629		87,108	21,921	13
14	30	DEPRECIATION	AVAIL. CENSUS DAYS	634,333	8	40,461		87,108	5,556	14
15	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	634,333	8	(18,956)		87,108	(2,603)	15
16	34	BUILDING RENT	AVAIL. CENSUS DAYS	634,333	8	76,619		87,108	10,521	16
17	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	634,333	8	49,932		87,108	6,857	17
18	39	ANCILLARY	AVAIL. CENSUS DAYS	634,333	8	253	208	87,108	35	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,492,919	$ 900,414		$ 205,011	25

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	37	8	720,633	720,000	5	93,249	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	40	8	154,447	151,667	5	20,078	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	12	8	12,200	12,000	1	626	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35	1	3,500	3,500			4
5	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	37	8	15,274		5	1,976	5
6	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	40	8	7,034		5	914	6
7	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	12	8	1,028		1	53	7
8	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35	1	317				8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 914,433	$ 887,167		$ 116,896	25

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JLR MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	61	9	$ 163,800	$ 163,800	3	$ 8,056	1
2	21	OFFICE	AVG. HOURS WORKED	61	9	5,235		3	257	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	61	9	7,210		3	355	3
4										4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	46,296				7
8										8
9										9
10	17	MARK BERGER-CONS. FEES	AVG. HOURS WORKED	40	2	15,000		7	2,500	10
11	21	SECRETARIAL	AVG. HOURS WORKED	40	2	5,000		7	833	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 242,541	$ 163,800		$ 12,001	25

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	608,174	14	$ 274,940	$ 273,771	41,975	$ 18,976	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	608,174	14	6,646		41,975	459	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	608,174	14	11,535		41,975	796	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	608,174	14	81,974	63,989	41,975	5,658	4
5	24	SEMINARS	CARE PATH FEES	608,174	14	449		41,975	31	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	608,174	14	47,810		41,975	3,300	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 423,354	$ 337,760		$ 29,220	25

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Diamond Insurance
Street Address: 40 Skokie Blvd.
City / State / Zip Code: Northbrook, IL 60062
Phone Number: (847) 559-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct Allocation			$	$		$ 94,121	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 94,121	25

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	South Shore Limited Partner	X		Mortgage			$	$ 9,104,391			$ 724,703	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	X		Working Capital				3,000,000			362,645	6
7												7
8												8
9	TOTAL Facility Related						$	$ 12,104,391			$ 1,087,348	9
	B. Non-Facility Related*											
10	Supplemental Schedule										(11,050)	10
11	Interest Income										(13,628)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (24,678)	14
15	TOTALS (line 9+line14)						$	$ 12,104,391			$ 1,062,670	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/ # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income (Building Co.)	X					$	$			$ (8,447)	1
2	Allocation from NuCare	X									(2,603)	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (11,050)	21

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	280,146	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	375,185	2
3. Under or (over) accrual (line 2 minus line 1).	$	95,039	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	429,133	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	524,172	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998	2,872	11
1999	408,698	12

Accrual: 408,698 X 1.05 = $429,133

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT S(# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,865 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 357,697
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 6,734
4. Dates Incurred: 1998

Nature of Costs: Organization Costs, Mortgage Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	42,825		$ 651,589	1
2					2
3	TOTALS	42,825		$ 651,589	3

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	238			1998	$ 9,209,684	$ 322,794	35	$ 263,134	$ (59,660)	$ 605,561	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WIRE PAGING SYS			1998	1,060	27	20	53	26	110	9
10	CAR STOPS			1998	2,256	200	20	113	(87)	245	10
11	ELECTRICAL WORK			1998	1,027	26	20	51	25	106	11
12	METAL DOOR FRAME			1998	516	13	20	26	13	54	12
13	CARPET			1998	895	23	20	45	22	98	13
14	WINDOW TREATMENT			1998	12,317	316	20	616	300	1,335	14
15	UNDERGROUND UTIL			1998	3,000	77	20	150	73	313	15
16	COMPUTER CABLING			1998	277	7	20	14	7	29	16
17	KICK PLATES,CHAIR RA			1998	4,326	111	20	216	105	468	17
18	PARKING STALL MARKS			1998	325	8	20	16	8	33	18
19	POWER WASH PAINT			1998	800	21	20	40	19	83	19
20	FACILITY SIGN			1998	9,146	491	20	457	(34)	990	20
21	LANDSCAPE ARCH			1998	6,850	176	20	343	167	743	21
22	DRAINAGE & AIRLINES			1998		14	20		(14)		22
23	SHELVES			1998	976	25	20	49	24	107	23
24											24
25	PAGE 12-1 REP TOTALS				2,907	214		120	(94)	247	25
26											26
27											27
28											28
29											29
30											30
31	PAGE 12E TOTALS				3,895	68		141	73	141	31
32	PAGE 12D TOTALS				51,547	870		1,799	929	1,799	32
33	PAGE 12C TOTALS				51,318	1,103		2,185	1,082	3,393	33
34	PAGE 12B TOTALS				73,479	3,474		3,675	201	6,357	34
35	PAGE 12A TOTALS				15,418	16,276		771	(15,505)	1,658	35
36	TOTAL (lines 4 thru 35)				$ 9,452,019	$ 346,334		$ 274,014	$ (72,320)	$ 623,870	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLPAPER			1998		385	20		(385)		9
10	AWNINGS			1998		351	20		(351)		10
11	ITEX FUNDS			1998		10,766	20		(10,766)		11
12	INSTALL WALLPAPER			1998		190	20		(190)		12
13	CORNER GUARDS			1998		30	20		(30)		13
14	MIRRORS & TABLE TOPS			1998		80	20		(80)		14
15	RELOCATE BED FIXTURE			1998		49	20		(49)		15
16	INSTALL WALLPAPER			1998		138	20		(138)		16
17	INSTALL WALLPAPER			1998		47	20		(47)		17
18	PAT FINN SALARY			1998		3,084	20		(3,084)		18
19	BANNER & SIGNS			1998	1,687	43	20	84	41	182	19
20	WALLPAPER			1998		9	20		(9)		20
21	ROOM SIGNS			1998	2,181	56	20	109	53	236	21
22	FLOOR TILES			1998		8	20		(8)		22
23	KICK PLATES			1998	3,455	89	20	173	84	375	23
24	FENCE			1998	1,584	142	20	79	(63)	165	24
25	SHELVES			1998	1,031	26	20	52	26	107	25
26	SCOUNCES			1998		19	20		(19)		26
27	AWNING			1998		159	20		(159)		27
28	ELECTRICAL WIRING			1998		148	20		(148)		28
29	RELOCATE HVAC			1998		42	20		(42)		29
30	CERAMIC TILE			1998		34	20		(34)		30
31	WALL SCOUNCES			1998		189	20		(189)		31
32	DRYING RACK			1998	3,789	97	20	189	92	410	32
33	PRINTER CABLING			1998	394	10	20	20	10	42	33
34	THERMGUARD MOUNTS			1998	1,297	33	20	65	32	141	34
35	PATIO CARPET			1998		52	20		(52)		35
36	TOTAL (lines 4 thru 35)				$ 15,418	$ 16,276		$ 771	$ (15,505)	$ 1,658	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLPAPER			1998		17	20		(17)		9
10	LAWN SPRINKLERS			1998	398	501	20	20	(481)	43	10
11	COMPUTER CABLING			1998	406	10	20	20	10	43	11
12	BUILD PARTITIONS			1998	2,016	52	20	101	49	219	12
13	CARPET			1998		238	20		(238)		13
14	LANDSCAPE ARCH			1998	2,400	62	20	120	58	260	14
15	WALLPAPER			1998		45	20		(45)		15
16	SECURITY SYSTEM			1998	12,515	321	20	626	305	1,356	16
17	CARPET			1998		34	20		(34)		17
18	WINDOW TREATMENTS			1998		36	20		(36)		18
19	PLEATED SHADES			1998		50	20		(50)		19
20	TILE			1998		50	20		(50)		20
21	WALLPAPER			1998		68	20		(68)		21
22	WALLPAPER			1998	1,182	30	20	59	29	128	22
23	CUBICLES,DRAPES			1998		323	20		(323)		23
24	FENCE			1999	4,500	115	20	225	110	300	24
25	SECURITY CAMERAS			1999	3,410	87	20	171	84	314	25
26	FENCE TO PATIO AREA			1999	4,000	103	20	200	97	267	26
27	WINDOW TOPS			1999	3,840	98	20	192	94	272	27
28	WALL SYSTEM			1999	2,100	54	20	105	51	131	28
29	CARPET			1999	1,135	29	20	57	28	76	29
30	ELECTRICAL WORK			1999	3,228	83	20	161	78	242	30
31	LANDSCAPING			1999	24,156	619	20	1,208	589	2,013	31
32	KEY SYSTEM			1999	2,920	75	20	146	71	195	32
33	ASPHALT DRIVEWAY			1999	3,440	327	20	172	(155)	344	33
34	SIGNS FOR LOT			1999	733	19	20	37	18	49	34
35	CANOPY			1999	1,100	28	20	55	27	105	35
36	TOTAL (lines 4 thru 35)				$ 73,479	$ 3,474		$ 3,675	$ 201	$ 6,357	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CARD READER ACCESS			1999	1,325	34	20	66	32	132	9
10	SPRINKLERS			1999	3,335	86	20	167	81	264	10
11	SPRINKLERS			1999	590	15	20	30	15	40	11
12	IMPROVEMENT			1999	614	16	20	31	15	41	12
13	IMPROVEMENT			1999	671	17	20	34	17	45	13
14	CABLE & CAMERA			1999	1,560	40	20	78	38	150	14
15	PHONES			1999	2,487	64	20	124	60	238	15
16	OUTLETS			1999	891	23	20	45	22	86	16
17	WALLGUARD			1999	651	17	20	33	16	58	17
18	CARPET			1999	4,345	111	20	217	106	416	18
19	HVAC INSPECTION			1999	3,279	84	20	164	80	191	19
20	CCTV & INTERCOM ACCE			1999	3,585	92	20	179	87	358	20
21	ELECTRICAL WORK			1999	4,900	126	20	245	119	306	21
22	WALLPAPER			1999	90	2	20	5	3	10	22
23	WIRING FOR SIGN			1999	2,717	70	20	136	66	272	23
24	SIGN & POSTS			1999	269	7	20	13	6	26	24
25	PAGER SYSTEM			1999	1,257	32	20	63	31	126	25
26	TOILET SEATS			1999	865	22	20	43	21	86	26
27	SIGNS			1999	727	19	20	36	17	72	27
28	CONTROL PANEL			2000	1,561	18	20	39	21	39	28
29	REPAIR FIRE ALARM PA			2000	841	10	20	21	11	21	29
30	REMOTE CONTROL MOUNT			2000	1,501	21	20	44	23	44	30
31	SCREENS			2000	630	3	20	8	5	8	31
32	LOWER LEVEL MAINTANC			2000	5,985	96	20	199	103	199	32
33	FURNISH & INSTALL NE			2000	935	17	20	35	18	35	33
34	FOUNDATION FOR SIGN			2000	5,000	48	20	104	56	104	34
35	9 LATCH GRDS/DEADBLT			2000	707	13	20	26	13	26	35
36	TOTAL (lines 4 thru 35)				$ 51,318	$ 1,103		$ 2,185	$ 1,082	$ 3,393	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	RELOCATE ELECTRICAL			2000	440	6	20	13	7	13	9
10	REPLACE WROUGHT IRON			2000	450	6	20	12	6	12	10
11	LOCKS, KEYS			2000	775	11	20	23	12	23	11
12	INSTALL NEW PHN LINE			2000	1,431	23	20	48	25	48	12
13	WALL COVERING			2000	1,216	12	20	25	13	25	13
14	SIGN			2000	3,905	71	20	146	75	146	14
15	DAVID THOMAS MOCH			2000	696	4	20	9	5	9	15
16	REPLACE FREIGHT ELEV			2000	1,750	13	20	29	16	29	16
17	PARKING GARAGE STGE			2000	3,945	80	20	164	84	164	17
18	ELECTRICAL WORK			2000	704	1	20	3	2	3	18
19	INSTALL LANDSCAPING			2000	972	9	20	20	11	20	19
20	WALLPAPER			2000	1,973	2	20	8	6	8	20
21	SHRAGE FENCE			2000	1,166	6	20	15	9	15	21
22	WALL MOUNTED DISPENS			2000	1,118	8	20	19	11	19	22
23	INSTALL WALL MOUNTED			2000	220	1	20	3	2	3	23
24	REPAIR FIRE PUMP CON			2000	570	6	20	12	6	12	24
25	INSTALL ADD'L WASHER			2000	787	3	20	7	4	7	25
26	WANDER GUARD			2000	12,600	256	20	525	269	525	26
27	PHONE TIRES			2000	1,310	21	20	44	23	44	27
28	LOCKS AND PASSAGE SE			2000	1,156	26	20	53	27	53	28
29	6 DUAL BED SIDE STAT			2000	541	8	20	16	8	16	29
30	CICERO DEVELOPMENT			2000	1,292	1	20	5	4	5	30
31	REMOTE CONTROL MOUNT			2000	932	13	20	27	14	27	31
32	FURNISH & INSTALL LO			2000	3,382	83	20	169	86	169	32
33	CABLEING			2000	1,326	33	20	66	33	66	33
34	FURNISH & INSTALL TI			2000	5,482	135	20	274	139	274	34
35	REPAIR/REPLACE AWNIN			2000	1,408	32	20	64	32	64	35
36	TOTAL (lines 4 thru 35)				$ 51,547	$ 870		$ 1,799	$ 929	$ 1,799	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELECTRICAL WORK IN 4			2000	2,074	42	20	87	45	87	9
10	REPLACE 2 LOCK BDS			2000	1,212	25	20	51	26	51	10
11	WALLPAPER			2000	609	1	20	3	2	3	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 3,895	$ 68		$ 141	$ 73	$ 141	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from NuCare Services Corp.			1997	632	16	20	32	16	102	9
10	Allocation from NuCare Services Corp.			1998	554	14	20	28	14	68	10
11	Allocation from NuCare Services Corp.			1999	777	175	20	39	(136)	56	11
12	Allocation from NuCare Services Corp.			2000	944	9	20	21	12	21	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,907	$ 214		$ 120	$ (94)	$ 247	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE .# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,093,869	$ 188,567	$ 67,271	$ (121,296)		$ 55,827	37
38	Current Year Purchases	67,303	12,652	4,009	(8,643)		4,009	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 1,161,172	$ 201,219	$ 71,280	$ (129,939)		$ 59,836	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 11,264,780	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 547,553	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 345,294	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (202,259)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 683,706	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT SOUTH SHORE
0042085
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Renaissance at South Shore	232,029	65,039	23,209	(41,830)	41,004
South Shore Limited Partnership	835,092	119,299	41,754	(77,545)	
NuCare Services	26,748	4,229	2,308	(1,921)	14,823
TOTALS	1,093,869	188,567	67,271	(121,296)	55,827
LINE 29: CURRENT YEAR					
Renaissance at South Shore	61,623	11,539	3,689	(7,850)	3,689
South Shore Limited Partnership					
NuCare Services	5,680	1,113	320	(793)	320
TOTALS	67,303	12,652	4,009	(8,643)	4,009
LINE 30: FULLY DEPRECIATED					
Renaissance at South Shore					
South Shore Limited Partnership					
NuCare Services					
TOTALS					
TOTALS (Should Tie to Totals on Page 13)					
Renaissance at South Shore	293,652	76,578	26,898	(49,680)	44,693
South Shore Limited Partnership	835,092	119,299	41,754	(77,545)	
NuCare Services	32,428	5,342	2,628	(2,714)	15,143
TOTALS	1,161,172	201,219	71,280	(129,939)	59,836

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE R # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		238		$			3
4	Additions							4
5	Allocation from Nucare				10,521			5
6	Land Rent - South Shore Limited Partnership				12,000			6
7	TOTAL		238		$ 22,521 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 12,315 Description: Copiers $5458; Allocation from Nucare $6857
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	1999 Lexus RX300	$ 540.00	$ 6,480	17
18					18
19					19
20					20
21	TOTAL		$ 540.00	$ 6,480	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE AT S # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 120

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$ 1,595	$ 5,049	$	$ 6,644
2	Books and Supplies				
3	Classroom Wages (a)	6,084	19,267		25,351
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 7,679	$ 24,316	$	$ 31,995
10	SUM OF line 9, col. 1 and 2 (e)	$ 31,995			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	19
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	6
2. From other facilities (f)	
TOTAL TRAINED	25

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSAN # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 134,202	$		$ 134,202	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			32,195			32,195	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			142,665			142,665	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				92,084		92,084	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2					84,605		84,605	13
14	TOTAL			$		$ 309,062	$ 176,689		$ 485,751	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCI # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	9,685
5	Bed Rental	42,784
6	Enteral Feeding	20,791
7	Lab	10,666
8	Urological	679
9		
10		
		84,605

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE R1# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,500	$ 259,853	1
2	Cash-Patient Deposits	1,120	1,120	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,060,103	4,060,103	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,221	23,221	6
7	Other Prepaid Expenses	42,250	42,250	7
8	Accounts Receivable (owners or related parties)	1,000	1,000	8
9	Other(specify): See supplemental schedule	663,062	917,305	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,793,256	$ 5,304,852	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		651,589	13
14	Buildings, at Historical Cost		8,876,835	14
15	Leasehold Improvements, at Historical Cos	918,111	918,111	15
16	Equipment, at Historical Cost	293,651	1,128,743	16
17	Accumulated Depreciation (book methods)	(184,584)	(1,150,931)	17
18	Deferred Charges		231,904	18
19	Organization & Pre-Operating Costs		3,485	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(2,091)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	250	250	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,027,428	$ 10,657,895	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,820,684	$ 15,962,747	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,603,570	$ 1,603,570	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	255,558	255,558	30
31	Accrued Taxes Payable (excluding real estate taxes)	41,031	41,031	31
32	Accrued Real Estate Taxes(Sch.IX-B)	429,134	429,134	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(2,064)	(2,064)	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	2,315,619	2,659,704	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,642,848	$ 4,986,933	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,000,000	3,000,000	39
40	Mortgage Payable		9,104,391	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,000,000	$ 12,104,391	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,642,848	$ 17,091,324	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,822,164)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,820,684	$ #REF!	48

***(See instructions.)**

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE # 0042085 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	169,649	169,649
Due from Employees	14,855	14,855
Insurance Escrow	21,000	21,000
Replacement Reserve	171,370	171,370
Deferred Income Tax	27,930	27,930
Investment in Partnership	258,258	258,258
Real Estate & Insurance Escrow		37,569
Replacement Reserve Escrow		197,194
MIP Escrow		19,480
	663,062	917,305

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		
Accrued R. E. Tax - Non Care Property		
Due to Affiliates	1,930,171	1,930,171
Accrued Management Fees	353,514	353,514
Accrued Rent	31,933	31,933
Advance from Related Entities		99,967
Tenant Replacement Reserve Escrow		171,370
Tenant Tax & Insurance Escrow		72,748
	2,315,618	2,659,703

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Loan Costs		
Deposit	250	250
	250	250

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSA # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,872,056)	1
2	Restatements (describe):		2
3	Schedule attached	(256,844)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,128,900)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	306,736	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 306,736	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,822,164)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	THE CLARIDGE OF SOUTH SHORE #	0042085	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(2,128,900)
Adjustments:		
		-
		-
		-
		256,844
Total adjustments		256,844
Balance - Beginning of Year		(1,872,056)
Equity(Deficit) from Page 17 Col 1		(1,822,164)
Related Party		
Equity(Deficit)	693586	
Income	0	
		693,586
Combined Equity - End of Year		(1,128,578)

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,746,839	1
2	Discounts and Allowances for all Levels	(572,215)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,174,624	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	423,777	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 423,777	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	152,742	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,643	19
20	Radiology and X-Ray		20
21	Other Medical Services	42,532	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 223,917	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,628	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,628	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	7,259	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,259	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,843,205	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,548,632	31
32	Health Care	3,653,123	32
33	General Administration	2,211,491	33
	B. Capital Expense		
34	Ownership	2,440,229	34
	C. Ancillary Expense		
35	Special Cost Centers	552,332	35
36	Provider Participation Fee	130,662	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,536,469	40
41	**Income before Income Taxes (line 30 minus line 40)****	306,736	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 306,736	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number THE CLARIDGE OF SOUTH SHOI # 0042085 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2	Food Rebates (Adjusted out on page 5)	860
3	Copies (Adjusted out on page 5)	1,217
4	Jury Duty (Adjusted out on page 5)	103
5	IDPA Provider Tax Credit	465
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	2,645

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,041	2,091	$ 74,951	$ 35.84	1
2	Assistant Director of Nursing	2,566	2,887	72,408	25.08	2
3	Registered Nurses	29,737	31,306	666,913	21.30	3
4	Licensed Practical Nurses	42,016	44,751	733,012	16.38	4
5	Nurse Aides & Orderlies	146,561	152,812	1,119,889	7.33	5
6	Nurse Aide Trainees	4,052	4,072	25,351	6.23	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,881	13,359	113,883	8.52	8
9	Activity Director	4,180	4,262	62,007	14.55	9
10	Activity Assistants	15,875	16,892	112,299	6.65	10
11	Social Service Workers	7,175	7,616	83,183	10.92	11
12	Dietician					12
13	Food Service Supervisor	4,986	5,313	72,811	13.70	13
14	Head Cook	5,701	6,118	51,911	8.48	14
15	Cook Helpers/Assistants	22,855	23,940	144,667	6.04	15
16	Dishwashers					16
17	Maintenance Workers	6,024	6,441	93,905	14.58	17
18	Housekeepers	8,686	8,848	63,080	7.13	18
19	Laundry	2,121	2,237	15,776	7.05	19
20	Administrator	2,050	2,107	88,399	41.95	20
21	Assistant Administrator					21
22	Other Administrative	2,273	2,331	57,156	24.52	22
23	Office Manager					23
24	Clerical	20,520	21,939	299,164	13.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,232	5,623	93,274	16.59	31
32	Other Health Care(specify)					32
33	Other(specify)	3,336	3,833	66,581	17.37	33
34	TOTAL (lines 1 - 33)	350,868	368,778	$ 4,110,620 *	$ 11.15	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	354	$ 14,348	1-3	35
36	Medical Director	Monthly	28,513	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,976	10-3	39
40	Physical Therapy Consultant	173	7,870	10a-3	40
41	Occupational Therapy Consultant	206	8,430	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	24	2,618	10a-3	43
44	Activity Consultant	17	420	11-3	44
45	Social Service Consultant	140	6,050	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	914	$ 71,225		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	488	$ 21,120	10-3	50
51	Licensed Practical Nurses	472	117,126	10-3	51
52	Nurse Aides	1,011	61,523	10-3	52
53	TOTAL (lines 50 - 52)	1,971	$ 199,769		53

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSANCE # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing Salary	1,298	1,439	$ 36,982	$ 25.70
Other Non-Reimb Salary	2,038	2,394	29,599	12.36
	3,336	3,833	$ 66,581	$ 17.37

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Berger (01/01/00-02/26/00)	Administrator	0	$ 18,813
Patrick Scales (01/07/00-12/31/00)	Administrator	0	69,586
Mark Berger	Executive Admin.	0	21,155
Barry Carr	Administrative	0	36,001
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 145,555

B. Administrative - Other

Description	Amount
Management Fees - JLR	$ 120,000
Management Fees - NuCare Services Corp.	228,466
Management Fees - Robert Hartman	120,000
Management Fees - Carepath	41,975
TOTAL (agree to Schedule V, line 17, col. 3)	$ 510,441
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Stone, McGuire & Benjamin	Legal	$ 5,939
Segal & Segal	Legal	6,875
Winston & Strawn	Legal	10,000
Kimberly Weissman	Legal	1,501
Barbara Demos	Legal	880
Sachnoff & Weaver	Legal	10,148
Frost, Ruttenberg & Rothblatt	Accounting	49,442
Purchasing Plus	Purchasing Service	600
Initial Security	Security Service	80,393
Personnel Planners	Unemployment Consultants	2,173
See Attached	Computer Services	20,966
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 188,917

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,178
Unemployment Compensation Insurance	91,582
FICA Taxes	297,222
Employee Health Insurance	35,747
Employee Meals	19,618
Illinois Municipal Retirement Fund (IMRF)*	
Payroll Taxes	9,008
Chicago Head Tax	8,590
Other Employee Benefits	27,381
Union Health & Welfare	48,498
Union Pension	19,530
TOTAL (agree to Schedule V, line 22, col.8)	$ 626,354

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	5,818
(Indicate # of checks performed 695)	
Classified Advertising	26,467
Licenses, Permits, Fees	3,214
Dues	8,965
Dues & Subscriptons	916
Employee Recruitment	17,500
Allocation from Carepath/Nucare	3,938
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 66,818

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,031
Allocated from Nucare	1,081
Allocated from Carepath	31
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,143

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE F # 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number THE CLARIDGE OF SOUTH SHORE, INC. d/b/a THE RENAISSAN(# 0042085 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on LTC $8965**

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,692** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **130,662**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **19,618** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw